experience in the use of this drug for this condition in almost 400 patients has been reported by Hammerstein *et al*[1] and they noted significant improvement in hirsuties in the majority of cases. They recommend a "reverse sequential" regimen using a dose of 100 mg of cyproterone acetate on days 5-14 of the cycle, combined with 50 μg of ethinyl oestradiol on days 5-25. The latter drug is added for cycle control and certain contraception.

Using this regimen we have demonstrated a marked reduction in the rate of growth as well as the diameter of the individual hairs.[2] Beneficial results with this drug have also been reported by Barnes *et al.*[3]

The drug is primarily a competitive inhibitor of androgens at the receptor level,[4] but it also inhibits steroid synthesis.[5] Because of this effect caution is necessary in its use, and adrenal insufficiency has been reported in children being treated for precocious puberty.[6] However, the study by Hammerstein *et al* found no evidence of adrenal impairment.

Your comments on women's attitude to excessive body hair are more optimistic than our current experience indicates and perhaps rather flippant. We have found that, although the condition is not serious medically, these women are extremely anxious and agitated by their condition, sometimes seeking psychiatric assistance. Certainly the necessity for frequent shaving is very distressing to them. Their mood dramatically changes, however, when they can see the benefits from the treatment.

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[1] Hammerstein, J, *et al*, *Journal of Steroid Biochemistry*, 1975, **6**, 827.
[2] Thomas, A K, Ebling, F J, and Cooke, I D, *British Journal of Obstetrics and Gynaecology*, in press.
[3] Barnes, E W, *et al*, *Clinical Endocrinology*, 1975, **4**, 65.
[4] Neumann, F, and Graf, K-J, *Journal of International Medical Research*, 1975, **3**, supplement (4) 1.
[5] Panesar, N S, and Stitch, S R, *Journal of Endocrinology*, 1976, **69**, 3, 14P.
[6] Girard, J, and Baumann, J B, *Journal of Endocrinology*, 1976, **69**, 3, 13P.

Art of general practice

SIR,—May I welcome your new series "Clinics in General Practice." The consultant's comments were excellent and succinctly made. The trainer, with reference to diarrhoea and pyrexia, has missed the teaching point of the case. The art of general practice is to remember that "common things are common," but the wise GP keeps the small print diagnosis up his sleeve. In small children one of the more common causes of diarrhoea and pyrexia is upper respiratory infection. One of the rarer (besides intestinal infections of salmonella nature) is appendicitis.

DEREK A COFFMAN

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Reliable detection of ruptured membranes

SIR,—Many antenatal patients are hospitalised because of doubt as to whether there has been a spontaneous leak of liquor. Furthermore, their management as regards early delivery may also depend on the definitive knowledge as to whether the membranes are intact. Tests to differentiate between the alkalinity of liquor and the acidity of vaginal fluid and urine were described in the 1930s.[1 2] However, our inquiries suggest that few obstetricians use such tests and many were unaware of them. We have therefore carried out a study of the efficacy of sterile nitrazine yellow-coated swabs mounted on sticks (Medical Wire and Equipment Co (Bath) Ltd). These swabs indicate a change to an alkaline pH by turning blue when even a small amount of liquor is present at the external cervical os.

A correct positive result was obtained in 75 patients whose membranes had been ruptured artificially one to four hours earlier and a correct negative result was obtained in 74 patients who were swabbed at the antenatal clinic during the third trimester. In one further antenatal patient a negative result was obtained during premature labour, but the membranes were found to be clinically ruptured 48 hours later. Other swabs were taken from patients with blood (13) and meconium (8) stained liquor, and a positive result was still obtained. Swabs from antenatal and gynaecological patients with proved trichomonal or monilial vaginitis did not give clinically false results. Lastly, vaginal swabs were taken in the presence of Hibitane cream, Hibitane solution, and KY jelly, and again clinically false results were not obtained.

We believe that nitrazine yellow swabs provide a very cheap and effective way of differentiating a leak of liquor from urine or vaginal discharge. We recommend a cervical swab taken by a sterile technique rather than a low vaginal swab, as it is possible that contamination of the lower vagina with urine (which occasionally is alkaline) may give a false positive result, and similarly a low vaginal swab may miss small amounts of liquor at the cervix.

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[1] Berlind, M M, *American Journal of Obstetrics and Gynecology*, 1932, **24**, 198.
[2] King, A G, *American Journal of Obstetrics and Gynecology*, 1935, **30**, 860.

Curry kidney

SIR,—I was most interested to read your leading article on the curry kidney (10 July, p 69). You observed on the basis of the two small studies that in Fiji the Indians are "virtually the only sufferers from stones." Further, you suggested that the similarity between the ingredients in Worcestershire sauce and curry may be the clue to the pathogenesis of renal stones. Singapore is a mixed ethnic community with a significant proportion of curry-consuming Indians. A recent study of 254 hospital patients of the different ethnic groups resident in Singapore,[1] including Indians from different parts of India, failed to demonstrate any statistically significant increase in the incidence of renal calculi among Indians.

There were 49 Indians, 177 Chinese, 24 Malays, and 4 other patients in the study. Indians accounted for 19·3% of the patients seen while they constituted 7·0% of the population of Singapore. The apparent increase is explained by the fact that the hospital utilisation figures showed that Indians constitute 14·3% of patients seen. Furthermore, the age and sex distribution of the Indian population in Singapore is peculiar. There is a preponderance of Indian males in the 20 to 59 age group in the population. This is the population at increased risk of renal stone disease.[2]

Multiethnic communities are interesting sources of epidemiological information, but enthusiasm in interpretation of small numbers studied has to be tempered by a statistical analysis which takes in important variables. While curries and Worcestershire sauce may continue to spice the aetiology of renal stone disease, the meat of the matter still escapes our notice.

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[1] Tambyah, J A, *et al*, *Singapore Medical Journal*, 1972, **6**, 269.
[2] Lavan, J N, *et al*, *Medical Journal of Australia*, 1971, **2**, 1049.

Hazard of glutethimide

SIR,—A patient with osteomalacia was referred by Dr G R Clarke when working in this department for further investigation in the department of metabolic diseases. She was detected as having hepatic enzyme induction leading to rapid vitamin D destruction caused by prolonged glutethimide administration.[1] This hazard had not been previously reported but is an additional contraindication to prolonged administration of glutethimide and possibly barbiturates not mentioned in your leading article (12 June, p 1424).

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[1] Greenwood, R H, Prunty, F T G, and Silver, J, *British Medical Journal*, 1973, **195**, 643.

Hormonal pregnancy tests and congenital malformations

SIR,—According to a reliable medical source some general practitioners are still using hormonal pregnancy tests despite the warning notice issued last year by the Committee on Safety of Medicines.[1] In view of the possible fetal damage which might be induced with this method of pregnancy diagnosis[2–4] the information requires thorough checking—even if it is based on hearsay evidence. This practice may have arisen from certain confusing factors.

The warning notice referred to 12 different preparations which were used for pregnancy testing, of which only Primodos and Norlestrin are available at present. The former product (manufactured by Scherings Chemicals, Ltd) has been recognised primarily for pregnancy testing, and proved to be very popular,[2] whereas the latter one (a Parke-Davis product) had the reputation of being an oral contraceptive and was less frequently used for diagnostic purposes. These products are now recommended for the symptomatic treatment of secondary amenorrhoea, and the manufacturers' data sheets have been revised accordingly.[5]

The fact that these two products remained on the market while the others were withdrawn may formulate false confidence. The warning remarks on the adverse effect in pregnancy.

which is included in the revised description of Primodos, could escape the notice of those general practitioners who had been using this product in the past; as it is most unlikely that the drug specification is read on all occasions in such circumstances. That the appearance of the product closely resembles the original could be also misleading. In reinforcing the warning notice, the introduction of further preventive measures seem to be needed.

There are many possible practical solutions, one of which might be to change the name of the products which were formerly recommended for pregnancy testing, and which are at present indicated for the treatment of secondary amenorrhoea—as already suggested in my previous letter to the *BMJ*.[6]

ISABEL GAL

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[1] Committee on Safety of Medicines; Adverse Reactions Series No 13, June 1975.
[2] Gal, I, Kirman, B, and Stern, I, *Nature*, 1967, **216**, 83.
[3] *British Medical Journal*, 1974, **4**, 485.
[4] Greenberg, G, *et al*, *British Medical Journal*, 1975, **2**, 191.
[5] Data Sheet Compendium, 1976, 691 and 849.
[6] Gal, I, *British Medical Journal*, 1975, **2**, 749.

The hospitals we need

SIR,—Your leading article on the hospitals we need (25 September, p 713) prompts me to raise the subject of the "hospital care at home" service operating in several parts of France.

Freda Clarke[1] points out that many patients, given the necessary care at home, would neither want nor need to go into hospital. After an uncertain start just such a service was launched 15 years ago in France and is functioning effectively in many areas of that country. The service in Paris, for example, provides personnel to maintain 1000 beds and in Bayonne 300 beds. The unit cost per bed is considerably less than for a traditional hospital bed, while the initial outlay and capital cost of setting up the service is minimal compared with the expense of converting an out-of-date cottage hospital into a community hospital.

The basic aims of the service, says Mrs Clarke, are as follows: (*a*) To co-ordinate the possibility of treatment which already exists; (*b*) to put at the disposal of patient and doctor the essential personnel to ensure adequate supervision and care; (*c*) to provide essential materials to improve the comfort of the patient. Requests for the service must come from the general practitioner or, in the case of early discharge from hospital, from the hospital doctor. A social worker from the service confirms the suitability of the case for home care and submits her report to the medical controller.

The personnel making up a unit within the service comprise a senior nurse, who carries out the procedures prescribed by the patient's doctor. A junior nurse allocated to the case is supervised by the senior nurse. A new category of worker has been introduced to meet the needs of the service. This is the *aide soignante*, or the caring aid. When the medical and nursing needs are minimal the *aide soignante* can be replaced by a home help.

I have little doubt that there will be those, particularly at administrative level, who will contend that what can be made to work in France, with its less than comprehensive health service, would not be feasible in Britain, with its uniquely comprehensive National Health Service. Following reorganisation in 1974 and the disappearance of the tripartite system of administration the opportunity for a more flexible planning policy, particularly in the realm of community medicine, became manifest.

Since the report of the Oxford University Health Service Evaluation Group has shattered the idea that unit cost in a community hospital is less than that of a bed in a district hospital I would suggest that the time is now opportune to give serious thought to setting up a hospital care at home service in this country. Such a service would certainly cope with the types of case mentioned in your editorial as being suitable for care in a community hospital. In addition there would be many others. In the course of my work as a regional medical admissions officer attached to the London Emergency Bed Service I frequently have to invoke the medical referee procedure in referring a patient to an already full hospital, not because the patient has some complicated medical condition that cannot be treated at home but simply for custodial care which is not available at home. Frequently, because a patient cannot await assessment by a geriatrician and possible admission in a week or two, he has to be foisted on to an acute medical ward, where he is likely to languish for many weeks, or even months, when acute and geriatric areas of responsibility are not conterminous.

I welcome the suggestion in your editorial that one or two regions should be offered the opportunity of a pilot scheme to decide on the policy that would provide the best compromise between medical efficiency and what the patient wants. I should like to suggest that pari passu with this should run a pilot scheme to assess the effectiveness and cost efficiency of a hospital care at home service.

A L DE SILVA
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[1] Clarke, F, *Health and Social Service Journal*, 1976, **86**, 348.

Form Med 3

SIR,—I find the layout of the new Med 3 frustrating. The space allocated to the FPC for stamping details of the doctor's name and address is excessive. On the contrary the area allowed for the doctor's statement is as small as it seems its value is considered. Times have changed!

G A READETT
Honorary secretary,
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Birmingham

SIR,—I should like to congratulate the General Medical Services Committee that after 25 years of serious negotiating they have managed to get the Form Med 3 changed from horizontal to vertical. Well done!

PATRICIA PIKE

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Frozen increments

SIR,—It is our belief that the Government will be quite unbending in respect of the frozen increments and that to reduce our work load is unprofessional, unrealistic, and unworkable. We feel that the Review Body should be persuaded to correct the anomalies created by its 1975 report whereby, for example, consultants with three annual increments were reduced to one new annual increment. At the time this seemed illogical and has now become unfair in the light of newly appointed consultants being given one, two, or even three increments.

We propose that the Negotiating Subcommittee of the CCHMS press the Review Body to award increments to all consultants on the basis of their years in post—for example, a consultant appointed five years should get five increments. This would correct the majority of the anomalies and injustices caused by the freezing of increments and would be a fair and logical step for the Review Body to take.

R H BAKER
M D BEETHAM
M J BROWN
D R CULLEN
G A B DAVIES-JONES
T DUCKWORTH
D M HARRIS
M O HINDLE
A E JEPHCOTT
P J MOORHEAD
W MORRIS-JONES
D R NAIK
A PADFIELD
M A PRENTON
F E PRESTON
B ROSS
J D SHAW
L SPITZ
J D WARD
D J K WHITE
A M WILSON
E WORTHY

Sheffield

Health Service charges

SIR,—Surely the time has now come when the Government should grasp the nettle and charge for the use of the Health Service? I believe that, though there would be an initial outcry, the majority of people would now be willing to accept that they have to make the choice between a serious deterioration in the quality and quantity of medical care on the one hand and a modest payment on the other hand for medical care by a high-quality service. I suggest that a charge of 50p per prescription and 50p per visit to the doctor's surgery would be reasonable and would help to reduce the work load of family doctors by discouraging unnecessary visits and unnecessary prescriptions; and that £1 be charged for each visit by the family doctor to the home, and £1 for each night in hospital. Exceptions would be made for children under 7 and for pensioners.

It would have to be made clear that all moneys so received would be put into the Health Service and not into the national exchequer.

RONALD ILLINGWORTH

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BMA representation in hospitals

SIR,—I should like to endorse the suggestion of Drs J M Cundy and W F Whimster (18 September, p 702) that there should be grassroots representation of the BMA in the hospital service. However, I will go further than the suggestion that there should be one doctor in each district conveying and receiving the BMA's views. I believe that there should be one such person in each unit (analogous with the unit administrator, who seems to have replaced the hospital secretary).

R G PRIEST

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